SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	6/1/2003
Sub-section	Medications		
Policy	Medication Administration	**Last Revised:**	DRAFT
Director's Approval	Alice Gleghorn, PhD	**Date**	
PHF Medical Director's Approval	Ole Behrendtsen, MD	**Date**	
Supersedes:	Medication Administration rev. 12/27/2016	**Audit Date:**	DRAFT

1. PURPOSE/SCOPE

1.1. To provide standards and procedures for the safe administration of medications for the patients admitted to the Psychiatric Health Facility (PHF).

1.2. To ensure all medications are administered in compliance with federal and state laws and standards of professional practice.

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. **MAR** – Medication Administration Record, part of a patient's permanent medical record.

2.2. **PRN** – Medication ordered without specific administration times and given on an as needed basis with parameters per a physician's order.

2.3. **Licensed nursing staff (LNS)** – an individual employed or contracted by the PHF who holds a valid California license as a: registered nurse (RN); licensed vocational nurse (LVN); or psychiatric technician (PT).

2.4. **Prescriber** – PHF psychiatrists, staff physicians, or nurse practitioners who order medications for patients.

3. POLICY

3.1. All medications are ordered by PHF psychiatrists, staff physicians or nurse practitioners (hereafter referred to as "prescriber"), and are administered by LNS.

3.2. LNS must adhere to the seven "rights" of medication administration:

1. Right Patient
2. Right Medication
3. Right Dose
4. Right Route
5. Right Time and Frequency
6. Right Reason
7. Right Documentation

3.3. Medications are administered within 60 minutes before or after the scheduled administration time unless an order allows for a broader timeframe.

3.4. Medication orders may be written using the approved list of abbreviations.[1]

4. MEDICATION ORDERS

4.1. Orders for scheduled medications must include the rationale for which the medication is being given.

4.2. Orders for PRN medications must include specific indications for when the medication is to be administered and must be documented in the MAR.[2] Additional documentation may be recorded in the nurse's notes. Results of the PRN must be documented in the medical record within one (1) hour of administration.

4.3. New medication orders will be double checked by the assigned night staff to ensure accuracy. The prescriber's order will be checked and compared with the MAR. The assigned night staff will sign the prescriber's order sheet (in red ink) stating the medication transcription is accurate, or correct any errors.

4.4. When a medication order is changed, the existing order will be discontinued and a new replacement order written.[3]

4.5. Written orders may not be altered except to correct an error by drawing a single line through the error, accompanied by the signature and discipline, date and time of the error correction.

4.6. If a patient is not given medications per prescriber-ordered parameters (e.g., if a patient refuses the medication or medication is held), after 7 days of the patient not receiving the medication, notify the patient's treating physician and current prescriber for consideration

[1] Please refer to PHF policy "Standard Abbreviations" for further details.
[2] Please refer to PHF policy "PRN Medications" for further details.
[3] Please refer to PHF policy "Documenting and Auditing Medication Order Changes" for further details.

of discontinuation of the medication. Documentation will be noted on the back of the MAR and flow sheet.

4.7. If at the time of discharge a patient has not been receiving a medication per prescriber-ordered parameters (e.g., if a patient refuses the medication or medication is held), patient's physician will be notified when obtaining discharge medication orders.

5. ADMINISTRATION PROCEDURES

5.1. Prior to administering any medication, the assigned medication nurse will:

1. Practice hand hygiene and prepare the administration area with all necessary supplies.
2. Minimize or eliminate distractions and interruptions.
3. Check a patient's chart for medication allergies and ensure this information is written prominently on the cover of patient's chart and on every medication order sheet.
4. Ensure a current informed consent for psychotropics medications is in place.[4]
5. Check labels for expiration dates or transcription errors.
6. Ensure he/she has the right patient before any medications are administered. Two (2) forms of identification are required. A current photograph, confirmation by the patient's assigned LNS or asking the patient to verbalize his/her date of birth may be used.
7. Compare the MAR with the written prescriber's order to ensure accuracy.
8. Compare the medication label with the MAR and repeat the comparison with the prescriber's order.
9. Document the administration in the MAR by placing his/her initials and license discipline in the box that corresponds with the date and time the medication was given.
10. If the medication is by injection (intramuscular or subcutaneous), document the site of injection using the site code listed on the back of the MAR.
11. When giving insulin from a sliding scale, document the exact dose given on the MAR in addition to the injection site code. The blood glucose levels will be documented by the nurse.
12. If a medication is written with vital sign parameters, document the required vital signs in the same box in which the medication is signed off.
13. Monitor and document the patient's response to the medications administered.

5.2. Medications will be administered only by the staff preparing them and may not be pre-poured before the patient receives them.

5.3. Medications must not be administered if staff have any concerns regarding consistency, color, odor or the presence of precipitants. Any concerning issues or findings must be

[4] Please refer to PHF policy "Informed Consent for Psychiatric Medications" for further details.

reported to the Nursing Supervisor and documented via an Unusual Occurrence Incident Report.[5]

6. REFUSALS AND MEDICATIONS NOT ADMINISTERED

6.1. When a medication is refused or not administered, the assigned medication nurse will:

1. Circle his/her initials in red ink on the MAR.
2. On the reverse side, document the reason the medication was refused or not administered. Document the name of the patient's physician who was notified of the refusal.
3. Place his/her initials, signature and license discipline in the corresponding section.
4. Also document refusal on the PHF Daily Flow Sheet (Attachment A); information documented here should align with the MAR documentation. Additional information can be documented in the narrative section of the PHF Daily Flow Sheet if needed.

6.2. Any unused portion of any single medication dose will be discarded per the PHF's medication disposal procedures.[6]

6.3. If the patient refuses any ordered medication, LNS will inform the prescriber. The notification will be documented in the medical record.

6.4. Based on his/her scope of practice, an LNS may place a medication on hold following an evaluation of the patient's disposition (e.g. blood pressure reading) and inform the prescriber.

7. MEDICATION EDUCATION

7.1. LNS will provide medication teaching opportunities and will document the activity on the *Medication Education Flow Sheet* (see Attachment B) for each patient.

7.2. When education is provided, LNS will document on the Medication Education Flow Sheet:

1. What information was provided and taught by listing the class of drug and the medication name.
2. What mode was utilized to educate the patient (i.e. Verbal, Written or Demonstration).
3. The patient's comprehension of what was taught.
4. Their name, initials and license discipline.

[5] Please refer to PHF policy "Unusual Occurrence Reporting" for further details.
[6] Please refer to the PHF policy "Medication Disposal" for further details.

REFERENCE

Code of Federal Regulations - Condition of Participation: Nursing Services
Title 42, Chapter IV, Sections 482.23(c)(1) and (c)(2)

California Code of Regulations – Licensing and Certification of Health Care
Title 22, Chapter 9, Sections 77079.5(b) and 77079.7

Business and Professions Code – California Nurse Practice Act, Scope of Regulation
Division 2, Chapter 6, Article 2. Subsection 2725 (b)(2)

ATTACHMENTS

Attachement A – PHF Daily Flow Sheet

Attachment B – Medication Education Flow Sheet

RELATED POLICIES

Standard Abbreviations

PRN Medications

Documenting and Auditing Medication Order Changes

Unusual Occurrence Reporting

Informed Consent for Psychiatric Medications

Medication Disposal

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION
DRAFT	2.1	• Added language around documentation of med refusals. • Added directions for nursing staff regarding medications not administered.
12/27/16	2.0	• Significant changes made to update medication orders, administrative procedures and patient education.

Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).

Santa Barbara County Department of Behavioral Wellness

PSYCHIATRIC HEALTH FACILITY– Daily Flow Sheet

	Date:	07-19	19-07	Document for each shift using the following format
Daily Shift Assessment	**Observation Level:** Q15; 1:1 ES; 1:1 AL			**B** = Behavior that shows the patient has an acute mental illness (specific descriptive behaviors that require intervention and hospitalization) **I** = Interventions in response to the patient's behavior(s). Use the Treatment Plan to guide interventions. **R** = Response to interventions, progress towards identified treatment goals **P =** next step in the plan of care/recommendations for Treatment Plan ***** *Asterisked items in Shift Assessment are to be evidenced/addressed in shift note*
	Hours slept this shift:			
	Meals: % Eaten B:			
	L:			
	D:			
	Snack: Health Shake:			
	Bathing/Grooming/Oral Hygiene **S** =Self **A** = With Assist **P** = Prompting required **T** = Total care			**Problem #_____ _____** **Problem #_____ _____** **Problem #_____ _____** **Problem #_____ _____**
	BM* (*if no BM in 24 hrs, document intervention)			
	Voiding			
	Diagnostics Completed: (circle below) **R** = refused CBC/BMP/UA/UDS/EKG/EEG/MRI/XRAY			
Daily Mental Status Assessment	**Alert and Oriented X /3**			**Nursing Note: Legible Date/Time/Signature and Title with each entry**
	Memory: (+) Intact (-) Impaired			
	Judgment: (+) Intact (-) Impaired			
	Thought Content: Logical			
	Hallucinations*			
	Delusions*			
	Tangential*			
	Blocked*			
	Grandiose*			
	Paranoid*			
	Risk Assessment: None			
	Suicidal Ideation*			
	Homicidal Ideation*			
	Seclusion & Restraint*			
	Affect: Appropriate			
	Inappropriate*			
	Blunted/Restricted*			
	Flat*			
	Hostile*			
	Depressed*			
	Euphoric*			
	Labile*			
	Mood: Appropriate			
	Depressed*			
	Labile*			
	Anxious*			
	Irritable*			
	Interaction: Participating			
	Withdrawn/Isolative*			
	Intrusive/Disruptive*			
	Hostile/Aggressive*			
	Initials of nurse completing assessment			

Patient Label

Daily Physical Status Assessment	Date:	07-19	19-07	
	Appearance: Appropriate			
	Disheveled*			
	Bizarre*			
	Speech: Clear/normal			
	Pressured*			
	Loud*			
	Slurred*			
	Slow*			
	Soft*			
	Mute*			
	Ambulation/Gait:			
	Steady/Unassisted			
	Unsteady*			
	Shuffling*			
	With Assistance* (indicate **W** = walker, **WC** = wheelchair)			
	EPS Evaluation: no signs			
	Fine Tremor*			
	Facial Twitching*			
	Restlessness*			
	Rigidity*			
	Drooling*			
	Shuffling*			
	V/S Stable (Yes or No*)			
	Med Compliant (Yes or No*)			
	Emergency Meds Utilized*			
	Initials of nurse completing assessment			

Alternative Group Activity

Time Start/ End	Staff Signature and title	Group Alternative * With Doctor's Order	Patient's Response
		Read Paper/Book Activity of Daily Living Off Unit Walk* Face to Face Conversation Journaling Listen to Music Watch TV Other:	Cooperative Refused with Prompting
		Read Paper/Book Activity of Daily Living Off Unit Walk* Face to Face Conversation Journaling Listen to Music Watch TV Other:	Cooperative Refused with Prompting
		Read Paper/Book Activity of Daily Living Off Unit Walk* Face to Face Conversation Journaling Listen to Music Watch TV Other:	Cooperative Refused with Prompting

Daily Vital Signs

Time	Blood Pressure	Pulse	Resp	Temp	Pain (scale, location)	Weight	Staff Initial

Female patients: **Menstruating? Y N N/A**

Date	Print Name and title	Initials	Signature	Date	Print Name and title	Initials	Signature

County of Santa Barbara
Department of Behavioral Wellness
Psychiatric Health Facility

Medication Education Flow Sheet

Date	Drug Class Medication Name	Type of teaching: **D**emo **V**erbal **W**ritten	Education Evaluation: 0 = Unable to participate 1= Able to participate; further education needed 2 = Verbalize/Demonstrate understanding	Training provided by:
	Antipsychotic			
	Antidepressant			
	Mood Stabilizer			
	Benzodiazepine			
	Antipyretic/Analgesic			
	Other:			

Patient Sticker